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Recently, I was discussing political issues with my 18-year-old daughter when I told her that Congress was on the verge of asking her generation to pay for my prescription medicines for the rest of my life. "Why?" she asked in amazement. This led to a broader discussion of the economics of health care and why the cost of health care is so high and even out of reach for many ordinary, hard-working Americans.

One of the reasons health care costs so much today is that it involves far more high technology than it did in the past. Thanks to things like CT (computerized tomography) scans, MRI (magnetic resonance imaging), expensive new "miracle" drugs, organ transplants and much else, formerly fatal diseases are being conquered, lives are being saved and people are living longer and longer. The United States has the best health care facilities and physicians in the world. Unfortunately, it all costs money. A lot of money.

But there is another big reason why health care costs so much. It is "cost shifting," a dirty little secret of health care. As our government has become increasingly involved with the economics and control of health care, it has mandated that certain groups of health care consumers subsidize the health care expenses of certain other groups.

The groups that have their health care subsidized include:

- Medicare patients
- Medicaid patients
- Workers' compensation patients
- Uninsured patients
- Illegal immigrants
- People with unhealthy lifestyles

Those who subsidize these groups include ordinary hard-working men and women who purchase health insurance either individually or through their employer. Because their health insurance payments help cover the medical expenses of subsidized groups, those payments are artificially high. Those who cannot afford this high cost either become members of a subsidized group or eventually become subsidizers any way when they have a medical emergency and must

America's Health Care Mess

Dirty Little Secrets Few Talk About

pay shockingly high "walk-up rates" for care. The walk-up rates are high for the same reason that health insurance premiums are – they include the cost of caring for the many members of the subsidized groups.

Medicare-Medicaid

Medicare, the federal program for the elderly, and Medicaid, the joint federal and state program for low-income citizens, are huge entitlements that cover over 80 million people (more than one in every four Americans) and cost over \$411 billion annually, or roughly 20 percent of the federal government's total annual expenditures of over \$2 trillion.

Medicare is a program of the U.S. Department of Health and Human Services. Medicaid is administered by individual state agencies under federal mandates, which generally specify who is eligible and the minimum level of benefits to be provided.

Because these two programs cover such a large percentage of the health care market, their administrators have the upper hand when it comes to setting rates. Laws and regulations make the system extremely rigid and stacked in favor of the government. It amounts to federal price fixing.

At most of the nation's hospitals, Medicare-Medicaid payments barely cover the basic costs of delivering the service. In fact, most hospitals actually lose money each time a Medicare-Medicaid patient is admitted. Those losses are, in turn, passed on to private payers who are not in the subsidized groups and to businesses that offer coverage to their employees.

Physicians do not do any better. Last year, Medicare payments to physicians were cut by 5.4 percent, and they were scheduled to be cut another 4.2 percent in 2004, until Congress made changes to the Medicare program just before Thanksgiving.

Hospitals and physicians, who are prohibited by law from joining together to negotiate rates, are individually almost powerless to do anything about this and must either accept the Medicare-Medicaid rates they are offered or else abandon a significant share of their patients.

Another dirty little secret is that the economics of what amount to federal price controls are indeed forcing physicians and hospitals to abandon their Medicare-Medicaid patients and to ration services to those they do care for. Here's what's happening:

- More and more health maintenance organizations (HMOs) are refusing to treat Medicare and Medicaid patients. Nationally, the number of HMOs participating in the "Medicare Plus Choice" plan has dropped by half, according to The Wall Street Journal.
- Individual physicians and clinics are refusing to treat Medicaid patients. In the Denver area for example, the Rocky Mountain News reports, just 21 percent of primary care physicians now accept new Medicaid patients. In some surrounding areas, less than 9 percent of physicians take new Medicaid patients.
- Private, specialty hospitals, many physician-owned, have sprung up across the nation to focus on sectors of medicine, such as gynecology and orthopedics, where the percentage of Medicare patients is lower. They do not provide emergency room services, and they discourage or refuse to take Medicaid patients. This "skimming" actually worsens the problem of cost shifting.
- It's still another dirty little secret among health care providers that in many hospitals around the country, informal rationing of scarce medical resources is taking place, with those "least able to benefit" getting the "short ration." This subtle triage of the elderly (see below) and other manifestations of rationing was recently documented in a series of Wall Street Journal articles titled "Who Gets Health Care? Rationing in an Age of Rising Costs."

Medicare's impact on cost shifting is magnified because of the high cost of treating elderly, terminally ill patients. A study of tens of thousands of Medicare beneficiaries that was published last year found that 22 percent of all medical expenditures for those over age 65 were made in the last year of life, and half of last-year inpatient expenses were incurred in the last month of life. Mean total medical expenditures in the last year of life, \$37,581, were over five times greater than mean expenditures of \$7,365 in other years.

(As one who will shortly complete my seventh decade, I'm hardly an advocate of the old Eskimo custom of leaving old folks out on the ice to die, but the question of how to handle high costs and scarcities demands serious and broad public discussion at the national level, not anonymous decisions quietly taken by individual physicians and hospital administrators.)

Workers' Compensation

Treating patients for injuries covered by Workers' Compensation is much the same. In Hawaii, the Legislature sets the rates offered to hospitals and physicians and they are often very low. The negative impact is less than in Medicare-Medicaid programs because Workers' Compensation is a much smaller part of the health care economy. However, in Hawaii, fewer and fewer physicians are willing to handle Workers' Compensation cases.

Uninsured

The problem of uninsured citizens and illegal immigrants (who are also uninsured, of course) has also become a significant economic factor in health care. Many in these categories gain admission to a hospital by arriving at the emergency room with a critical illness. Under federal law, the hospital must accept these patients and stabilize them before attempting to transfer them to another facility. If no other hospital is willing to accept the patient, the first hospital must continue to provide care, even though the patient has no health insurance and is unable to pay for treatment from his or her own resources. Even though some "emergency" Medicaid funding may be available in these cases, it covers only a fraction of the cost of care.

Of course, lack of insurance coverage is a problem not only for the health care system, but also – and particularly – for the many individuals who lack coverage. For them, it can be tragic, leading to serious untreated illness, impoverishment, or both. This is another powerful reason to fix the problem, along the lines suggested below.

In any case, the cost of treating patients without insurance and the unpaid portion of the cost of patients treated on Medicare, Medicaid, and Workers' Compensation programs do not simply disappear. They must be covered in some fashion. How? They are transferred to ordinary workers and the companies that sponsor their health care coverage.

Unhealthy Lifestyles

Add to this the fact that health care insurance companies, and the laws and regulations pertaining to health care insurance, lump together people with healthy lifestyles and those who make the bad personal choices that lead to poor health. These include smoking, obesity, poor dietary habits, alcoholism, and the use of illegal drugs, to name a few. If smokers, for example, had to pay more for their health insurance, as they do for life insurance, health care costs for non-smokers would be lower.

Malpractice Insurance

There is still another factor – the cost of malpractice insurance. Medicine continues to be as much an art as it is a science. Yet the American legal system has created an environment in which juries make huge awards when the outcome of treatment is not 100 percent perfect. As a result, physicians have to work the first four months of each year, on average, just to pay the premiums on malpractice insurance. This too adds to the cost of health care.

A recent Gallup Poll found that 72 percent of Americans favor capping "pain and suffering" awards in medical liability cases. A few states have succeeded in tort reform, but the politically well-connected American Trial Lawyers Association is vehemently opposed to any reforms that would reduce "lottery size" winnings in malpractice cases, according to Alan Miller, CEO of Universal Health Services, as quoted in the New York Post.

It is no wonder that the cost of health care insurance is so high. Ordinary, healthy families are subsidizing the health care costs of people on a number of government programs plus people with unhealthy lifestyles, and they are funding trial lawyers in a runaway malpractice system.

Those who are familiar with health care recognize that the current system is severely flawed and change is needed. The compromise \$400 billion (10-year cost estimate) Medicare prescription drug bill just passed by Congress includes some tentative steps toward solving some of these problems.

- It contains provisions for a very limited test of the injection of competitive market forces into the Medicare system.
- Physicians and HMOs will get increased payments for their services.
- Hospitals in border states will get additional funds to cover the losses they incur when they treat illegal immigrants.

Unfortunately, the bill also contains an 18-month moratorium on new physician-owned specialty hospitals, which will reduce competition. And, there is no real relief from the destructive shackles of federal price controls.

Moreover, these provisions do not really address the basic issues of greater government involvement in health care, cost shifting from certain groups of patients to others, and the many other flaws in the system identified by the bipartisan Medicare commission a few years ago.

The new prescription drug entitlement, while certainly helpful to senior citizens, some of whom are presently forced to choose between groceries and medications, will result in still more cost shifting. It is a shame it will not be accompanied by more serious efforts to reform the massive Medicare system. Something really needs to be done before the "baby boomer bubble" works its way into Medicare eligibility over the next decade or so. If not, the cost shifting problem will become intolerable, and the health care system will fall into complete disarray.

In the future, I hope Congress can muster the guts to really do the right thing. The chances of that happening seem remote however, because, as noted by Robert Bartley in *The Wall Street Journal*, Congressfolk rely neither on Medicare nor on the kind of health care insurance programs that cover most working Americans. Instead, they've given themselves an entirely different health care system based on competition and consumer choice not unlike the one I am suggesting below.

If I were emperor, I would radically change the way we pay for health care. Instead of providing employees and citizens eligible for Medicare-Medicaid with traditional one-size-fits-all insurance, employers and governments would fund individual Medical Savings Accounts with tax-free dollars. Beneficiaries could then buy their own insurance policies, using those funds.

Some would choose costly policies that cover all medical expenses, starting with the first dollar. Others would choose more economical plans that cover only major hospital-surgical expenses. Some would choose policies that offer substantial discounts for healthy lifestyles. Those who insist on pursuing risky behavior would pay more for their health care.

The marketplace would respond by offering numerous insurance options. Happily, the new Medicare bill included a provision for Health Savings Accounts, so we may soon begin to see the benefits of this enlightened measure.

If I can dream a little farther, I would also add significant reform of the malpractice court system and our immigration laws. Then there might be some real progress toward returning sanity to the economics of health care in the United States.

Those who are truly needy and fall outside the system sketched above would continue to be cared for through more traditional health care options. However, this would be "means tested," and hospitals and physicians would be paid at prevailing rates.

Back to reality. The whole U.S. health care system is in a state of artificial chaos and is likely to implode if we do not stop government-mandated subsidization of the costs of selected groups by ordinary workers and their employers. Until that day comes, we will continue to see cost shifting and health care insurance rates that for most people far exceed the value of the services they receive.

Editor's Note:

The name Richard Kelley should be very familiar to many of our readers, especially the senior ones. Dr. Kelley was a pathologist here in Hawaii and Assistant Professor of Pathology at our medical school.

Born in Honolulu to Roy and Estelle Louise Kelley, founders of the Outrigger Hotels, Richard was educated at Punahou, Stanford University and Harvard Medical School. After his internship and residency at the University of California San Francisco, he returned to Hawaii to serve as pathologist at The Queen's Medical Center and Kapiolani Maternity Hospital.

Dr. Kelley is now Chairman of the Board of Outrigger Enterprises. He founded the company in 1970 when he retired from pathology. His Outrigger chain is Hawaii's largest and most diversified hotel company, operating 60 owned or managed hotels and condo-hotels, including 33 in Hawaii.

He now lives in Colorado with his wife Linda van Gilder Kelley, and their two youngest children, Christopher (21) and Ann Marie (18). He keeps in touch with his 3,000 employees through the Outrigger's Saturday Briefing.

The Hawaii Medical Journal is pleased to reprint with permission, this Briefing, If restaurants were run like doctors' offices by Dr. Charles R. Kelley, Richard's son.